

# Stockport NHS Foundation Trust

## Inspection report

Stepping Hill Hospital  
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We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

## Ratings

### Overall trust quality rating

Requires improvement 

Are services safe?

Requires improvement 

Are services effective?

Requires improvement 

Are services caring?

Good 

Are services responsive?

Requires improvement 

Are services well-led?

Requires improvement 

Are resources used productively?

Requires improvement 

Combined quality and resource rating

Requires improvement 

# Summary of findings

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

## Background to the trust

Stockport NHS Foundation Trust provide services for children and adults across Stockport and the High Peak area, as well as community health services for Stockport. The trust operates from three hospital locations, 24 community locations across Stockport and their staff also provide care in people's homes. Stepping Hill Hospital is the trust's main acute site, which provides emergency, critical care, surgery, children's and young people services, end of life care and medical services. The medical services provided at the hospital include general medicine, endoscopy, cardiology, geriatric medicine, endocrinology, gastroenterology, rehabilitation, respiratory and stroke medicine. The trust also offers a specialist `hub` centre for emergency and high-risk general surgery, one of only four in Greater Manchester and covering the south-east sector of the region. The other hospital locations, Devonshire Centre for Neuro-rehabilitation and Bluebell Ward – The Meadows, deliver non-acute services.

The trust had 692 beds in November 2019. The trust had increased bed capacity during the winter period and had approximately an additional 60 beds open at the time of inspection. The trust holds approximately 1880 outpatient clinic appointments and 791 community clinic appointments each week. Stockport NHS Foundation Trust has a designated critical care unit with 13 beds for both level 2 and 3 patients. They provide midwifery care to 3,100 women and their families each year throughout the pregnancy within both hospital and community settings.

Between January 2019 and December 2019, there were 100,520 type one attendances at the department. Type one emergency departments provide full major emergency services and have resuscitation facilities. Between January 2019 and March 2019, there were a further 1,808 type three attendances at the service. Type three departments are for walk-in attendances for minor illness or injury.

The trust employs over 5,400 staff who work across a number of premises to deliver hospital and community-based services.

We have previously inspected Stockport NHS Foundation Trust. We inspected the trust in January 2016. It was rated as requires improvement. We carried out an unannounced focused inspection of Stepping Hill Hospital in March 2017. We carried out this inspection to particularly look at the care and treatment received by patients within urgent and emergency care and patients receiving medical care at the hospital.

The trust was last inspected in October and November 2018. It was rated as requires improvement. The use of resources was rated as inadequate.

## Overall summary

**Our rating of this trust stayed the same since our last inspection. We rated it as **Requires improvement****   
 

# Summary of findings

## What this trust does

Stockport NHS Foundation Trust provide services for children and adults across Stockport and the High Peak area, as well as community health services for Stockport. The trust operates from three hospital locations, 24 community locations across Stockport and their staff also provide care in people's homes. Stepping Hill Hospital is the trust's main acute site, which provides emergency, critical care, surgery, children's and young people services, end of life care and medical services.

The trust had 692 beds in November 2019. The trust had increased bed capacity during the winter period and had approximately an additional 60 beds open at the time of inspection. The trust holds approximately 1880 outpatient clinic appointments and 791 community clinic appointments each week. Stockport NHS Foundation Trust has a designated critical care unit with 13 beds for both level 2 and 3 patients. They provide midwifery care to 3,100 women and their families each year throughout the pregnancy within both hospital and community settings.

The trust employs over 5,400 staff who work across a number of premises to deliver hospital and community-based services.

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

## What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

At this inspection, we inspected urgent and emergency care, medical care, children and young people's services and maternity. This was because we had previously rated urgent and emergency care services as requires improvement, we had some concerns about medical care and maternity and we had not inspected children's and young people's services since 2016.

## What we found

### Overall trust

Our rating of the trust stayed the same. We rated it as requires improvement because:

- We rated safe, effective, responsive and well-led as requires improvement. We rated caring as good. We rated three of the trust's 13 services as requires improvement, one as inadequate and nine as good. In rating the trust, we took into account the current ratings of the nine services not inspected this time.
- We rated well-led for the trust overall as requires improvement.
- We rated urgent and emergency care as inadequate. We rated medical care, maternity and children and young people's services as requires improvement.

# Summary of findings

- Within urgent and emergency care, people were not always kept safe and were at high risk of avoidable harm during periods of heavy demand on the service.
- Risk assessments for patients with mental health needs were not being completed, meaning that opportunities to prevent or minimise harm were missed. We raised this with the trust and they took immediate action to address this.
- There was a lack of consistency in the effectiveness of the care, treatment and support that people received in some areas.
- There were significant issues with the flow of patients through the emergency department and the hospital so that patients were assessed, treated, admitted and discharged in a safe, timely manner. Emergency care was consistently unable to be provided in a timely way. Women could not always access the maternity service of their choice when they needed it. High numbers of patients were medically optimised and awaiting transfer or discharge.
- Governance and risk management systems were not always effective. There was a lack of oversight of key performance areas in the services.

However:

- There had been improvements, particularly within medical care, regarding staff knowing how to support patients who lacked capacity to make their own decisions or those who were experiencing mental ill health.
- We rated caring as good in medical care, maternity and services for children and young people.
- There was improved compliance with the Fit and Proper Persons Requirement (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).

## Are services safe?

Our rating of safe stayed the same. We rated it as requires improvement because:

- We rated safe as requires improvement in medical care, maternity and children and young people's services. We rated safe as inadequate in urgent and emergency care.
- Within urgent and emergency care, people were not always kept safe and were at high risk of avoidable harm during periods of heavy demand on the service. Safety systems and processes were not consistently used or monitored by staff and the premises, equipment and facilities did not always support staff to keep people safe.
- Within urgent and emergency care and the children's and young people's services, risk assessments for patients with mental health needs were not being completed, meaning that opportunities to prevent or minimise harm were missed. We raised this with the trust and they took immediate action to address this.
- The provider did not ensure sufficient numbers of nursing and medical staff completed mandatory and safeguarding training.
- Within urgent and emergency care, medical care and maternity, we found the trust did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment at all times.
- The trust did not consistently manage patient safety incidents well. Learning from incidents was not always shared across the trust.

## Are services effective?

Our rating of effective stayed the same. We rated it as requires improvement because:

- We rated urgent and emergency care and children and young people's services as requires improvement.

# Summary of findings

- Within urgent and emergency care, patients were at risk of not receiving effective care or treatment. There was a lack of consistency in the effectiveness of the care, treatment and support that people received.
- The trust did not always make sure staff were competent for their roles. Completion of appraisals was below trust targets across the services we inspected.
- Within services for children and young people, staff did not always know how to support children, young people and their families who were experiencing mental ill health.
- Key services were not always available seven days a week to support timely care for children, young people and their families.
- Within urgent and emergency care, patient outcomes were not always positive or met expectations in line with national standards.

However:

- We rated medical care and maternity as good for effective. These services provided care and treatment based on national guidance and evidence-based practice.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients in medical care.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients.
- Staff supported patients to make informed decisions about their care and treatment. There had been improvements, particularly within medical care: staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty appropriately.

## Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- We rated caring as good in medical care, maternity and services for children and young people.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.
- Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

However:

- We rated caring as requires improvement in urgent and emergency care. Staff were not always able to support, treat or care for patients with compassion and kindness during periods of heavy demand on the service. There were times when patients' privacy and dignity was not always maintained.

## Are services responsive?

Our rating of responsive stayed the same. We rated it as requires improvement because:

- We rated responsive as requires improvement for medical care and maternity services. We rated urgent and emergency care as inadequate.

# Summary of findings

- Urgent and emergency care services were not planned or delivered in a way that met people's needs during periods of heavy demand, and the facilities and premises did not always meet people's needs.
- There were significant challenges to patient flow within the medical care service. High numbers of medically optimised patients were awaiting transfer or discharge.
- People could not always access the service when they needed it during times of high demand in all medical specialities. People were frequently and consistently unable to access emergency treatment in a timely way and did not receive the right care promptly during periods of heavy demand. Waiting times from arrival to treatment and arrangements to admit, treat and discharge patients were consistently not in line with national standards. People experienced unacceptable waits for admission.
- Women could not always access the maternity service of their choice when they needed it. Service closures had progressively increased over the last three years.

However:

- We rated services for children and young people as good for responsive.
- These services planned and provided care in a way that met the needs of local people and the communities served.
- These services were inclusive and took account of patient's individual needs and preferences.

## Are services well-led?

Our rating of well-led stayed the same. We rated it as requires improvement because:

- We rated well-led as requires improvement in medical care, services for children and young people and maternity. We rated urgent and emergency care as inadequate. All of these ratings had deteriorated since our last inspection.
- Within urgent and emergency care, the delivery of high-quality care was not assured by the leadership, governance or culture. Leaders were not always in touch with the impact on patient care and staff morale as a result of continuing heavy demand and low staffing levels.
- Services did not always have a vision for what it wanted to achieve or a strategy to turn it into action. The trust strategy had been in development and was not yet launched.
- The culture in the services was mixed.
- Governance systems and processes were identified, however there was a lack of oversight of key performance areas in the services.
- Although leaders and teams had a system to identify risks, key risks were not always identified and actions to reduce the impact of risks were not always progressed.

## Use of resources

Our rating of use of resources improved. We rated it as requires improvement because:

The trust is in deficit and has an inconsistent track record of managing spend within resources. Although the trust has agreed the control total for 2019/20, at the time of the assessment there remained a number of risks associated with the delivery of this plan. Since the previous Use of Resources assessment in September 2018, the trust has seen some improvements and was able to demonstrate a number of areas of good practice, particularly within Pharmacy. However, the trust has also seen a number of metrics deteriorate and has faced particular challenges regarding operational performance over the previous 12 months.

Please see the separate use of resources report for details of the assessment and the combined rating.

# Summary of findings

## Combined quality and resources

Our rating of combined quality and resources stayed the same. We rated it as requires improvement because:

- We rated safe, effective, responsive and well led as requires improvement. We rated caring as good.
- The overall trust quality rating was requires improvement.
- The trust was rated requires improvement for use of resources.
- This gives a combined quality and resource rating of requires improvement.

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## Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

## Outstanding practice

We found examples of outstanding practice in medical care and maternity services at Stepping Hill Hospital.

For more information, see the Outstanding practice section of this report.

## Areas for improvement

We found areas for improvement including 25 breaches of legal requirements that the trust must put right. We found 56 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

## Action we have taken

We issued requirement notices to the trust and took enforcement action. Our action related to breaches of one legal requirement at a trust-wide level and five in core services.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

## What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

## Outstanding practice

The Sentinel Stroke National Audit Programme (SSNAP) audit identified the stroke services at the hospital as the top performing unit nationally. Stroke patients received care in a dedicated unit from a highly motivated and effective multidisciplinary team. We identified this as an area of outstanding practice.

The maternity service worked with outside agencies and volunteers to provide breastfeeding support in the postnatal period at a variety of venues including department store cafeterias.

# Summary of findings

The trust's quality team had developed a veteran's passport as a result of feedback from, and in conjunction with, a patient.

## Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve trusts.

### Action the trust **MUST** take to improve

We told the trust that it must take action to bring trusts into line with five legal requirements. This action related to four core trusts.

#### Trust level

- The trust must make significant improvements to ensure they have enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment at all times, and particularly during periods of heavy demand. (Regulation 18).
- The trust must ensure there are effective governance systems to monitor quality, safety and risk. Without these patients were, or may be, at risk of harm through the lack of identification of, and subsequent review and mitigation of risks. (Regulation 17).
- The trust must improve the flow of patients through the emergency department and the hospital so that patients are assessed, treated, admitted and discharged in a safe, timely manner. (Regulation 12(2)(b))

#### Urgent and Emergency Care

- The trust must ensure that care and treatment provided to service users during periods of heavy demand is appropriate, meets their needs and reflects their preferences. (Regulation 9)
- The trust must ensure that service users are treated with dignity and respect. (Regulation 10)
- The trust must ensure that care and treatment is provided in a safe way by assessing the risks to the health and safety of service users receiving the treatment, including service users presenting with mental health conditions, and doing all that is practicable to mitigate the risks. (Regulation 12)
- The trust must ensure that care and treatment is provided in a safe way by ensuring the premises are safe to use for their intended purpose. (Regulation 12)
- The trust must ensure there are sufficient quantities of equipment available to staff to provide care in a safe way and to meet the needs of patients. (Regulation 12)
- The trust must ensure that premises and equipment are suitable are safe to use and risks associated with ligature points have been identified and assessed. (Regulation 12)
- The trust must ensure that systems and processes are operated effectively to assess, monitor, improve the quality of care and experience of service users, and mitigate the risks associated with delivering the service. (Regulation 17)
- The trust must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff provide safe care and treatment to service users. (Regulation 18)

#### Medical care



# Summary of findings

- The trust must take appropriate action to continue to work with partners in the health economy to identify key drivers that affect access and flow on the medical care service so short- and long-term solutions improve the patient experience. Regulation 12 (2)
- The trust must take appropriate action to ensure that trust policies for managing violence and aggression are reviewed and implemented. Regulation 17 (2)
- The trust must take appropriate actions to ensure to systems and processes are operated effectively to assess, monitor and improve the quality of care and experience of service users, and mitigate the risks associated with delivering the service. Regulation 17 (2) (b)
- The trust must take appropriate action to ensure mandatory training and staff competencies meet the needs of the patients and staff. Regulation 18 (1)

## Maternity

- The trust must ensure that they ensure there are enough trained and competent staff to provide safe care to women and babies and that there is always a supernumerary labour ward co-ordinator at all times. (Regulation 18)
- The trust must ensure that safety procedures, designed to improve safety for mothers and babies, such as the World Health Organisations five steps to safer surgery are carried out regularly to adhere to national recommendations. (Regulation 17)
- The trust must assess, monitor and improve quality and safety of women and babies using the service. (Regulation 17)
- The trust must work to reduce closing the unit to improve access and flow for women using the service. (Regulation 9)

## Services for Children and young people

- The trust must ensure staff complete safeguarding training appropriate for the service and in accordance with guidance in 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth edition: January 2019'. Regulation 12(1)(2)(c),
- The trust must ensure risk assessments relating to the health, safety and welfare of people using services are completed and reviewed regularly by people with the qualifications, skills, and experience to do so Regulation 12(1)(2)(a).
- The trust must ensure that the premises are safe to use for their intended purpose and are used in a safe way. Regulation 12(1)(2)(d).
- The trust must ensure that effective systems for oversight of required training are implemented in the service. Regulation 17(1)(2)(a).
- The trust must ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the needs of the service. Regulation 18(1).
- The trust must ensure staff complete specific training for recognising and responding to children and young people with mental health needs, learning disabilities and autism. Regulation 18(1)(2)(a)

## Action the trust SHOULD take to improve

### Trust level

- The trust should review succession planning processes and implementation.
- The trust should review progress and take action on the delivery of recurrent cost improvement schemes.

# Summary of findings

- The trust should review arrangements for the audit committee's oversight of the overall system of internal control.
- The trust should consider the need to undertake a formal board effectiveness review.
- The trust should review pharmacy staffing levels.
- The trust should formally launch its overall strategy with key milestones.
- The trust should monitor services and hold them to account against clear priorities, agreed delivery metrics and deadlines.
- The trust should progress underpinning strategies to support the overall strategic direction, such as a clinical strategy.
- The trust should build the capability of the business groups to take forward key strategic initiatives.
- The trust should address cultural and behavioural issues creating a culture based around the trust's values and behaviours.
- The trust should review and implement the recommendations from the National Guardian's Office for Freedom to Speak Up.
- The trust should review the process and methodology for investigating incidents to encompass broader aspects and support learning across the trust.
- The trust should review and address issues regarding the antibiotic and sepsis data.
- The trust should review the corporate risk register and ratings to enable risk profiling and prioritisation.
- The trust should address the lack of a data warehouse to enable analytical capability in the business groups.
- The trust should review and continue to work to improve clinical, staff and partner engagement.

## **Urgent and Emergency Services**

- The trust should consider how it can improve staff availability for, and levels of attendance at, mandatory training courses.
- The trust should consider how it could improve its panic alarm system to quickly identify which room the alarm has been activated within.
- The trust should consider how it can encourage staff to be more responsive to patient call bells and requests for assistance during periods of heavy demand.
- The trust should consider how it could improve line-of-sight experience for children receiving care in cubicles in the paediatric department.
- The trust should review systems so the nutritional and hydration needs of service users, who may require assistance to eat and drink, are identified and met.
- The trust should consider enforce a no-smoking area immediately outside the entrance to the department adjacent to the paediatric waiting room window.
- The trust should consider reminding staff to ensure that sharps bins were 'part-closed' after use.
- The trust should ensure that infection prevention and control risks arising from vomit or urine spills are mitigated through timely cleaning.

# Summary of findings

- The trust should consider how it can improve oversight of patients in the waiting area, particularly where patients are at risk of deterioration while waiting.
- The trust should ensure it acts to improve the outcomes of patients as measured against national standards from the Royal College of Emergency Medicine.
- The trust should consider how it can improve the recording of consent for treatment obtained verbally.
- The trust should consider how it can increase staff knowledge of Gillick competence and support young people in consenting to care and treatment.
- The trust should consider how it can improve medical staff training compliance in Mental Capacity Act level one awareness.
- The trust should consider how it can improve the privacy and dignity of paediatric patients within the assessment cubicles, including how it could minimise distress caused to other children in the waiting area.
- The trust should ensure that staff are reminded to maintain basic standards of care, dignity and communication with patients at all times, even when demand is heavy.
- The trust should ensure staff maintain a professional curiosity around patients leave the department prior to being discharged to ensure risk of absconding is reduced.
- The trust should consider how it minimise the distress caused to patients living with dementia or learning disabilities who attend during periods of heavy demand and activity.
- The trust should consider how it can improve visibility and access to the formal complaints process on its website.
- The trust should ensure that it continues to engage with staff to improve the culture within the department, to reduce work related stress, and to support staff who are concerned about potential conflicts with their professional code of conduct as a result of heavy demands.
- The trust should consider how it can increase the visibility of senior leaders and executives in the department.
- The trust should ensure that it continues to work with partners in the health economy to identify key drivers to the increasingly heavy and unsustainable demands on the service and to ensure immediate, short and long-term solutions are identified to arrest and improve current performance against national standards.

## Medical care

- The trust should take appropriate actions for pharmacy cover to support to patients who are medical outliers and those on escalation wards is equitable with patient on dedicated medial wards.
- The trust should take appropriate actions to improve staff availability and attendance to complete mandatory training and staff competencies.
- The trust should take appropriate action to ensure there are sufficient storage and quantities of equipment available to staff to provide safe care and treatment.
- The trust should take action to improve performance in the lung cancer audit.
- The trust should take appropriate actions to improve cultural differences between medical specialists and clinicians.
- The trust should take appropriate actions to continue to ensure mandatory training meets the needs of the patients and staff for dementia, learning disabilities, autism and mental health.
- The trust should take appropriate actions to identify risks and mitigate action in a timely manner.

# Summary of findings

## Maternity

- The trust should consider monitoring when community when staff are moved from one clinical area to another to facilitate targeted improvement work.
- The trust should consider monitoring when staff have been redeployed from planned mandatory study days to work in the clinical area in order to facilitate targeted improvement work.
- The trust should work to reduce the increasing number of instances where the service is closed to admissions.
- The trust should consider monitoring the times that staff were redeployed from the birth centre in order to target improvement work.
- The trust should consider developing a documented vision and strategy.

## Services for Children and young people

- The provider should maintain complete records of children's diet and fluid intake.
- The provider should continue to complete incident records in a timely way and ensure all staff share in learning from incidents.
- The provider should review the implementation of safeguarding supervision across the service.
- The provider should implement appropriate systems to limit closures and ensure there is continued access to services from the children's ward.
- The provider should consider identifying a vision and strategy for the children and young people's service.
- The provider should identify ways to improve support staff and culture.
- The provider should review risk management approaches.

## Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our rating of well-led at the trust stayed the same. We rated well-led as requires improvement because:

We found the executive team were not sighted on some significant concerns, particularly in the emergency department. Since previous inspections, there had been a deterioration in some of the services we inspected.

Strategies to support the overall strategic direction, such as a clinical strategy, were being planned. The trust had recently approved a trust-wide strategy; the development had intentionally taken a long period of time, since the last inspection, to enable staff engagement but was yet to be formally launched.

There was a need to build the capability of the business groups to take forward key strategic initiatives. The strategic aim to strengthen health and social care partnerships in Stockport to achieve a more resilient urgent care patient pathway had commenced but was at an early stage of delivery.

There was an ambition to be a clinically-led organisation and this was not yet realised.

# Summary of findings

During this inspection we identified that there were continued gaps in the governance processes and board assurance. Assurance systems were not always comprehensive. Performance was monitored but was not always used to drive improvement.

The corporate and operational risk registers were cumbersome and there was a large number of significant risks which made risk profiling and prioritising difficult.

There were limits on the ability to interrogate available trust data and a recognition that information was used to provide assurance and reassurance, rather than to measure for improvement.

Engagement with external partners to enable system-wide improvements for patients had not always been effective. There were significant challenges to patient flow within the hospital. High numbers of medically optimised patients were awaiting transfer or discharge. A programme of work had begun to address this, but this had not yet had a significant impact.

We identified there were opportunities to improve clinical and staff engagement, although we acknowledged that steps had been taken to strengthen this.

We were told that concerns with a reported element of bullying and harassment or unacceptable behaviour had shown an increase over the last year. During the inspection, we were told by some staff that they had experienced a bullying culture.

However:

There was now a fully substantive executive team in place. The trust board had a range of skills, knowledge and experience. The trust leadership team had knowledge of current priorities and most of the challenges and were taking action to address them. There was recognition that the whole executive team were still a relatively newly formed team and further team development was planned.

The trust had a clear vision and set of values with quality as a top priority.

The trust had commissioned an external governance review which was underway and there was a planned restructure of executive portfolios and a further redevelopment of the governance approach for reporting risks.

The trust had improved compliance with the Fit and Proper Persons Requirement (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).

Information was available for leaders to enable them to have an understanding of performance.

Action was being taken to promote more cross-sector partnership working. There were positive examples of people who used the services and the public being engaged and involved to improvements.

We found that leaders and staff strived for continuous improvement and innovation. The trust was utilising external training for staff in nationally recognised quality improvement methodologies and staff were working together to make changes and improve services. There was evidence that they were engaged in research projects and were undertaking reviews internally and externally in order to improve services.

The trust had made improvements to elements of its safety performance over the last 12 months including a reduction in patients sustaining pressure ulcers in the community setting and a reduction in falls causing harm.

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## Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	↔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

\* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

### Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↔ 2020	Requires improvement ↔ 2020	Good ↔ 2020	Requires improvement ↔ 2020	Requires improvement ↔ 2020	Requires improvement ↔ 2020

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

### Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement ↔ 2020	Requires improvement ↔ 2020	Good ↔ 2020	Requires improvement ↔ 2020	Requires improvement ↓ 2020	Requires improvement ↔ 2020
Community	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Ratings for Stepping Hill Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ↓ 2020	Requires improvement ↔ 2020	Requires improvement ↓ 2020	Inadequate ↓ 2020	Inadequate ↓↓ 2020	Inadequate ↓ 2020
Medical care (including older people's care)	Requires improvement ↔ 2020	Good ↑ 2020	Good ↔ 2020	Requires improvement ↓ 2020	Requires improvement ↓ 2020	Requires improvement ↔ 2020
Surgery	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016
Critical care	Good Oct 2016	Good Oct 2016	Good Oct 2016	Requires improvement Oct 2016	Good Oct 2016	Good Oct 2016
Maternity	Requires improvement ↔ 2020	Good ↔ 2020	Good ↔ 2020	Requires improvement ↓ 2020	Requires improvement ↓ 2020	Requires improvement ↓ 2020
Services for children and young people	Requires improvement ↔ 2020	Requires improvement ↓ 2020	Good ↓ 2020	Good ↔ 2020	Requires improvement ↓ 2020	Requires improvement ↓ 2020
End of life care	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016
Outpatients	Good Oct 2016	Not rated	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016
<b>Overall*</b>	Requires improvement ↔ 2020	Requires improvement ↔ 2020	Good ↔ 2020	Requires improvement ↔ 2020	Requires improvement ↓ 2020	Requires improvement 2020

\*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Ratings for Devonshire Centre for Neuro-rehabilitation

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Dec 2018	Requires improvement Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018
<b>Overall*</b>	Good Dec 2018	Requires improvement Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018

\*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018
Community health services for children and young people	Good Aug 2016	Good Aug 2016	Outstanding Aug 2016	Outstanding Aug 2016	Outstanding Aug 2016	Outstanding Aug 2016
Community health inpatient services	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018
Community end of life care	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018
<b>Overall*</b>	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018

\*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.



# Stepping Hill Hospital

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Stockport  
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SK2 7JE  
Tel: 01614831010  
[www.stockport.nhs.uk](http://www.stockport.nhs.uk)

## Key facts and figures

Stepping Hill Hospital is the trust's main acute site, which provides emergency, critical care, surgery, children's and young people services, end of life care and medical services. The medical services provided at the hospital include general medicine, endoscopy, cardiology, geriatric medicine, endocrinology, gastroenterology, rehabilitation, respiratory and stroke medicine. The trust also offers a specialist `hub` centre for emergency and high-risk general surgery, one of only four in Greater Manchester and covering the south-east sector of the region.

The hospital has approximately 690 beds across 31 wards. The trust had increased bed capacity during the winter period and had approximately an additional 60 beds open at the time of inspection. The trust holds approximately 1880 outpatient clinic appointments. Stockport NHS Foundation Trust has a designated critical care unit with 13 beds for both level 2 and 3 patients. They provide midwifery care to 3,100 women and their families each year.

Between January 2019 and December 2019, there were 100,520 type one attendances at the department. Type one emergency departments provide full major emergency services and have resuscitation facilities. Between January 2019 and March 2019, there were a further 1,808 type three attendances at the service. Type three departments are for walk-in attendances for minor illness or injury.

We inspected Stepping Hill Hospital on 28 to 30 January 2020 and undertook a further inspection of the emergency department on 16 and 17 February 2020. During the inspection, we spoke with over 45 patients and family members, reviewed 107 sets of patient records and spoke with over 170 members of staff who worked at the hospital.

## Summary of services at Stepping Hill Hospital

**Requires improvement** ● → ←

Our rating of services stayed the same. We rated it them as requires improvement because:

- We rated safe, effective, responsive and well-led as requires improvement. We rated caring as good.
- We rated urgent and emergency care as inadequate. We rated medical care, maternity and children and young people's services as requires improvement.
- Within urgent and emergency care, people were not always kept safe and were at high risk of avoidable harm during periods of heavy demand on the service.

# Summary of findings

- Risk assessments for patients with mental health needs were not being completed, meaning that opportunities to prevent or minimise harm were missed. We raised this with the trust and they took immediate action to address this.
- There was a lack of consistency in the effectiveness of the care, treatment and support that people received in some areas.
- There were significant issues with the flow of patients through the emergency department and the hospital so that patients were assessed, treated, admitted and discharged in a safe, timely manner. Emergency care was consistently unable to be provided in a timely way. High numbers of patients were medically optimised and awaiting transfer or discharge. Women could not always access the maternity service of their choice when they needed it.
- Governance and risk management systems were not always effective. There was a lack of oversight of key performance areas in the services.

However:

- ▪ There had been improvements, particularly within medical care, regarding staff knowing how to support patients who lacked capacity to make their own decisions or those who were experiencing mental ill health.
- We rated caring as good in medical care, maternity and services for children and young people.

# Urgent and emergency services

Inadequate ● ↓

## Key facts and figures

Stockport NHS Foundation Trust has an Urgent Care Village approach to the delivery of urgent and emergency care. The emergency department provides care for all ages of patients attending with an urgent health problem either by self-presentation, ambulance or referral by a healthcare professional.

Patients are assessed and streamed to the most appropriate service for their needs (resus, majors, psychiatry, minor injury, primary care or direct to a specialty in the case of healthcare professional referrals) in either an adult or paediatric setting within the same footprint. Patients considered frail have additional assessments within the urgent care environment and, if admission is required, can be cared for on a dedicated Short Stay for Older People (SSOP) unit.

Patients presenting to the emergency department between the hours of 9am and 11pm with a stroke are immediately transferred to the co-located hyper acute stroke unit (HASU).

The site is one of three designated trauma units in Greater Manchester (GM) working within a wider network to ensure the best care for major trauma patients for whom safe transfer to immediate treatment is paramount.

A local NHS mental health trust provides assessment for patients presenting to ED with urgent mental health needs; this provider has an offices and assessment space within the department.

*(Source: Routine Provider Information Request (RPIR) – Sites tab)*

### Activity and patient throughput

From July 2018 to June 2019 there were 100,429 attendances at the trust's urgent and emergency care services as indicated in the chart above.

*(Source: Hospital Episode Statistics)*

Between January 2019 and December 2019, there were 100,520 type one attendances at the department. Type one emergency departments provide full major emergency services and have resuscitation facilities. Of these, 55,753 patients were treated in the department's 'majors' unit, 24,866 were treated in the department's 'minors' (minor illness/injury) unit, and 19,858 children were treated in the paediatric emergency department. The remaining 61 patients were treated in the department's resuscitation area.

Between January 2019 and March 2019, there were a further 1,808 type three attendances at the service. Type three departments are for walk-in attendances for minor illness or injury.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. Our first inspection visit took place over three days, and our second visit over two days. During this time, we spoke to 31 staff members, including senior leaders, managers, medics, nurses and therapy staff. We spoke with 26 patients, relatives or carers and reviewed a total of 41 patient records, five complaints, and eight serious incident investigation reports. We observed daily activity and clinical practice within the service. We also reviewed data relevant to the department that we received before and after the inspection which was provided by the trust.

## Summary of this service

Our rating of this service went down. We rated it as inadequate because:

# Urgent and emergency services

- The service's performance against a range of measures had deteriorated significantly since our last inspection. We identified a range of regulation breaches relating to patient-centred care, dignity and respect, safe care and treatment, environment and equipment, good governance, and staffing.
- People were not always kept safe and were at high risk of avoidable harm during periods of heavy demand on the service. Mandatory and safeguarding training rates were low. The service did not have sufficient nursing staff in post, relied heavily on bank and agency staff, and consistently did not meet the planned nursing establishment. We observed the impact of this on patients' basic care. Patient safety checklists, and some types of risk assessments were not being carried out, and staff did not always recognise and report incidents.
- People were at risk of not receiving effective care or treatment. There was a lack of consistency in the effectiveness of the care, treatment and support that people received. Staff did not routinely assess or assist patients with nutritional and hydrational requirements. Staff did not always recognise or respond to patients expressing pain during busy periods. Patient outcomes were not always positive or met expectations in line with national standards. The service could not assure itself that staff were competent for their roles.
- People were not always treated with compassion or involved in their care. There were breaches of dignity and significant shortfalls in the caring attitude of staff during periods of heavy demand. Staff focused on tasks rather than treating people as individuals and did not always recognise lapses in the maintenance of people's privacy and dignity or give it sufficient priority. Staff did not always support and involve patients, families and carers to understand their condition, what was going to happen to them or to make decisions about their care and treatment.
- Services were not planned or delivered in a way that met people's needs. Plans were not always effective at reducing demand on the service. The environment was not always suitable for patients presenting with mental health problems or living with dementia. People were frequently and consistently unable to access emergency treatment in a timely way and did not receive the right care promptly during periods of heavy demand. People experienced unacceptable waiting times.
- The delivery of high-quality care was not assured by the leadership, governance or culture. Leaders were not always in touch with the impact on patient care and staff morale as a result of continuing heavy demand and low staffing levels. Staff did not feel respected, supported, valued or appreciated. There were low levels of staff satisfaction, high levels of stress and work overload during periods of high demand. Plans to cope with unexpected events were not always effective as the approach to service delivery was mostly reactive. Delivery of quality of care was not sustainable during periods of heavy demand or low staff numbers.

However,

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- The service's frailty intervention team and functional risk equipment social and home environment team achieved positive results for admission avoidance through deflection of patients back home after assessment.
- The service treated formal concerns and complaints seriously and investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.
- Leaders operated governance processes, throughout the service and with partner organisations, that were mostly effective. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

# Urgent and emergency services

- Leaders and staff engaged with patients; they collaborated with partner organisations to plan and manage services.

## Is the service safe?

**Inadequate** ● ↓

Our rating of safe went down. We rated it as inadequate because:

- People were not always kept safe and were at high risk of avoidable harm during periods of heavy demand on the service. Safety systems and processes were not consistently used or monitored by staff and the premises, equipment and facilities did not always support staff to keep people safe.
- The service did not ensure nursing and medical staff completed the mandatory training in key skills.
- The service had safeguarding systems and processes in place to protect people from the risk of abuse. However, safeguarding vulnerable adult and children level three training was not given sufficient priority. Safeguarding adults and children training rates for nursing and medical staff were low.
- The service did not always control infection risk well. Staff inconsistently used equipment and control measures to protect patients, themselves and others from infection, although equipment and the premises were mostly observed to be visibly clean.
- The design, maintenance and use of facilities, premises and equipment did not keep people safe.
- Staff did not consistently assess, monitor or manage risks to people who use the services. Staff did not complete risk assessments for mental health patients, meaning that opportunities to prevent or minimise harm were missed. They did not consistently minimise environmental and safety risks. However, staff identified and acted on patient early warning scores for patients whose conditions were deteriorating.
- The service did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment at all times, and particularly during periods of heavy demand on the service. However, managers gave bank and agency staff a full induction.
- Staff did not always have access to up-to-date, accurate and comprehensive information on patients' care and treatment.
- The system for assurance on the storage of temperature sensitive medicines was not always effective.
- The service did not consistently manage patient safety incidents well; staff recognised but did not always reported incidents and near misses.
- Staff collected safety thermometer information and shared it with staff, patients and visitors. However, the service's audit of records indicated low average compliance with falls, tissue viability and catheter care assessments in the emergency department.

However,

- There were good levels of training compliance by medical staff with the highest forms of life support training.
- Although the number of medical staff in the service did not match the planned number; the service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

# Urgent and emergency services

- All staff had access to an electronic records system that they could all update. Records were clear, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, and record medicines.
- When incidents were reported, managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

## Is the service effective?

**Requires improvement** ● → ←

Our rating of effective stayed the same. We rated it as requires improvement because:

- People were at risk of not receiving effective care or treatment. There was a lack of consistency in the effectiveness of the care, treatment and support that people received.
- Staff did not always give patients food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary; however, there was no system in place for identifying and assisting patients who needed additional help to eat and drink.
- Staff assessed and mostly monitored patients to see if they were in pain and gave pain relief. However, during periods of heavy demand staff did not always recognise or respond to patients expressing distress due to pain.
- Staff monitored the effectiveness of care and treatment. Patient outcomes were not always positive or met expectations in line with national standards, but they used the findings to recommend improvements.
- The service could not assure itself that staff were competent for their roles. Managers did not always appraise staff's work performance or hold supervision meetings with them to provide support and development.
- Staff did not always record consent in the patient's records.

However,

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- The service's frailty intervention team and functional risk equipment social and home environment team achieved positive results for admission avoidance through deflection of patients back home after assessment.
- Staff assessed and mostly monitored patients to see if they were in pain and gave pain relief. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- The service had introduced a 'purple shift' to support medical and nursing staff to develop competencies or to provide advice.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.

# Urgent and emergency services

- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

## Is the service caring?

**Requires improvement** ● ↓

Our rating of caring went down. We rated it as requires improvement because:

- Staff were not always able to support, treat or care for patients with compassion and kindness during periods of heavy demand on the service. There were times when patients' privacy and dignity was not always maintained, and staff were not always able to take account of or meet patients' individual and basic needs.
- Staff did not consistently see the provision of emotional support to patients, families and carers to minimise their distress as a priority. Staff focused on tasks rather than treating people as individuals and did not always recognise lapses in the maintenance of people's privacy and dignity or give it sufficient priority.
- Staff did not always support and involve patients, families and carers to understand their condition, what was going to happen to them or to make decisions about their care and treatment. During periods of heavy demand, the service did not support a caring environment or approach to people's care, treatment and support.

## Is the service responsive?

**Inadequate** ● ↓

Our rating of responsive went down. We rated it as inadequate because:

- The service was not planned or delivered in a way that met people's needs during periods of heavy demand, and the facilities and premises did not always meet people's needs.
- The service did not consistently plan and provide care in a way that met the needs of local people and the communities served. Although the service worked with others in the wider system and local organisations to plan care; this was not always effective at reducing demand on the service.
- The design and layout of the service was not always suitable for patients presenting with mental health problems or living with dementia, particularly during periods of high demand.
- People were frequently and consistently unable to access emergency treatment in a timely way and did not receive the right care promptly during periods of heavy demand. Waiting times from arrival to treatment and arrangements to admit, treat and discharge patients were consistently not in line with national standards. People experienced unacceptable waits for admission.
- It was not always easy for people to raise immediate concerns with staff about their treatment and experiences at the point of care.

However,

- The service treated formal concerns and complaints seriously and investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

# Urgent and emergency services

## Is the service well-led?

**Inadequate** ● ↓↓

Our rating of well-led went down. We rated it as inadequate because:

- The delivery of high-quality care was not assured by the leadership, governance or culture. Leaders were not always in touch with the impact on patient care and staff morale as a result of continuing heavy demand and low staffing levels.
- Leaders did not consistently apply the skills and abilities to run the service safely at times of high demand. We were not assured they understood and managed the priorities and issues the service faced well. Leaders were not consistently visible and approachable in the service for patients and staff.
- There was no service-specific vision, mission statement or guiding values. Winter plans, short-term flow proposal plans, and long term plans for a new urgent care campus were in place and had recently been agreed with local stakeholders in the wider health economy. However, the plans lacked detailed actions, controls, or timescales to evidence realistic objectives or an effective approach to monitoring, measuring, reviewing or progress against delivery of the plans.
- Staff did not feel respected, supported, valued or appreciated. There were low levels of staff satisfaction, high levels of stress and work overload during periods of high demand. Staff were not always focused on the needs of patients receiving care. However, the service had an open culture where patients and their families could raise concerns without fear.
- Leaders and teams were aware of the risks faced by the service and the performance challenges. They identified and escalated relevant risks and issues but did not always identify actions quickly enough to reduce their impact. Plans to cope with unexpected events were not always effective as the approach to service delivery was mostly reactive. Delivery of quality of care was not sustainable during periods of heavy demand or low staff numbers.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.
- Opportunities for staff to learn and improve services were limited. There was inconsistent investment in improvement skills and systems among staff and leaders. Improvements were not always identified, and action was not always taken.

However,

- Leaders operated governance processes, throughout the service and with partner organisations, that were mostly effective. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.
- Leaders and staff engaged with patients; they collaborated with partner organisations to plan and manage services.



# Medical care (including older people's care)

Requires improvement   

## Key facts and figures

Medical care is provided on the Stepping Hill Hospital site, which is the trust's main acute site, and at its community units. The medical services provided at the hospital include; general medicine, gastroenterology, cardiology, medicine for older people, diabetes & endocrinology, respiratory, stroke medicine, rheumatology, haematology, oncology and rehabilitation. These services are currently provided across 16 inpatient areas including an offsite rehabilitation unit, the Devonshire Unit, and discharge to assess unit, the Bluebell facility. The inpatient areas are supported by multidisciplinary teams including nursing, medical, pharmacy, allied health professionals, health care assistants and social workers amongst others.

As an integrated care trust the medical care team works closely with community teams such as end of life care, enhanced care management team, integrated transfer team and intermediate care services to support care and discharge planning. The medical care team also works in partnership with external organisations such as other provider trusts, commissioners and third sector to support patient care.

The medical care team also provides diagnostic and treatment services which are managed through outpatient and day case or elective stays.

*(Source: Routine Provider Information Request AC1 - Acute context)*

The trust had 31,633 medical admissions from July 2018 to June 2019. Emergency admissions accounted for 22,096 (69.9%), 640 (2.0%) were elective, and the remaining 8,897 (28.1%) were day case.

Admissions for the top three medical specialties were:

General medicine – 24,252

Geriatric medicine – 2,571

Clinical haematology – 2,130

We inspected the medical care (including older people's care) service as part of our unannounced inspection between 28 and 30 January and 12 February 2020. We visited acute medical (AMU), assessment, ambulatory care unit (ACU), Endoscopy, B4, C4, A1, A3, coronary care unit (CCU) D4, D5, B3, A10 and C5. As part of our inspection we reviewed information provided by the trust about staffing, training and monitoring performance.

During our inspection we spoke to 51 members of staff including divisional leads, clinical leads, matrons, ward managers, nursing staff, support staff, pharmacists, pharmacy assistants, allied health professionals and social workers. We spoke to nine patients and relatives who were using the service at the time of our inspection. We reviewed a sample of 34 patient records and 28 prescription charts.

## Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service had not improved in all areas identified from our last inspection. Staff did not have training in key skills and the oversight of mandatory training and staff competency was unclear.
- Although staff understood how to protect patients from abuse, there was low compliance for completion of the required level of safeguarding training.

# Medical care (including older people's care)

- Leaders did not always manage the priorities of the service. The service had a system to identify risks but actions to reduce and mitigate risks were not always progressed in a timely manner.
- There were significant challenges to patient flow within the service. High numbers of medically optimised patients were awaiting transfer or discharge.
- Escalation wards and medical outlier's clinical pharmacy service was not equitable with other medical wards.
- The service reported safety incidents but opportunities for shared learning were limited.

However:

- Staff treated patients with compassion, kindness, respected their privacy and dignity and provided emotional support to patients and their families and carers.
- The service provided care and treatment based on national guidance and evidence-based practice. The service was focused on the needs of the patients and gave practical advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patient's consent. They knew how to support patients who lacked capacity to make their own decisions and reviewed patient's needs.

## Is the service safe?

**Requires improvement** ● → ←

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service provided mandatory training to all staff but did not always make sure everyone completed it.
- Not all staff had completed the required level of safeguarding training and the service lacked oversight of training levels.
- The estate was aged and we found some issues. On some wards there was limited space between beds which impacted on individual's privacy and the ward layout in a number of wards did not provide clear lines of sight to patients.
- Staff shortages were covered by locums, bank, supporting staff and ward managers working clinically when needed which was not sustainable.
- Care plans and risk assessments were not always accurately documented.
- The clinical pharmacy service to outlying patients and escalation wards was not equitable with other medical wards.
- Managers investigated incidents but, learning from incidents was not always shared in the wider service.

However:

- Staff we spoke to understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.

# Medical care (including older people's care)

- Staff kept detailed records of patients' care and treatment.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- Staff recognised incidents and near misses and reported them appropriately. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

## Is the service effective?

**Good** ● ↑

Our rating of effective improved. We rated it as good because:

- The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patient's consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty appropriately.

However:

- Managers appraised staff's work performance, but completion rates did not meet the trust target.

## Is the service caring?

**Good** ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

# Medical care (including older people's care)

- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.
- Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

## Is the service responsive?

**Requires improvement** ● ↓

Our rating of responsive went down. We rated it as requires improvement because:

- There were significant challenges to patient flow within the service. High numbers of medically optimised patients were awaiting transfer or discharge. The service worked with others in the wider system and local organisations to plan care, but this had not always been effective.
- People could not always access the service when they needed it during times of high demand in all medical specialities.
- Complaints about the service were not always responded to within the timelines specified by the trust policy.

However:

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.
- The service planned and provided care in a way that met the needs of most of the local people and the communities served.

## Is the service well-led?

**Requires improvement** ● ↓

Our rating of well-led went down. We rated it as requires improvement because:

- Leaders had the skills and abilities to run the service. Although they understood the issues the service faced, they had not always been able to prioritise them or effect positive changes.
- The service did not have clear vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.
- Although the service had governance structures and processes were followed, there was a lack of robust oversight in key areas.
- Leaders and teams used systems to identify risks, but key risks and actions to reduce the impact of risks were not always progressed in a timely manner.

However;

- Leaders and staff understood the trust's vision and strategy and knew how to apply this in monitoring progress.

# Medical care (including older people's care)

- Leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- Most staff felt respected, supported and valued. Staff were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.
- The service collected data. Data and notifications were submitted to external organisations as required.
- All staff were committed to continually learning and improving services. Understanding of quality improvement methods and the skills to use them was being developed.

# Maternity

Requires improvement  

## Key facts and figures

The trust provides midwifery care to approximately 3,100 women and their families per annum throughout the pregnancy continuum within both hospital and community settings.

The hospital-based service at Stepping Hill consists of an Antenatal Clinic, 18 bedded Labour Ward including theatre capacity and a recovery area, a combined 28 bedded Antenatal and Postnatal Ward and a co located 3-bed Birth Centre with a 4-bed postnatal area and a Triage / Antenatal Day Unit facility.

The hospital-based service is also supported by an established breastfeeding support service for women within the region.

Community based service offers an integrated Community Midwifery Service that provides antenatal and postnatal care within the community setting and an integrated 24hr homebirth service. In addition to the hospital and community services they also offer a traditional homebirth service and Community Midwifery service to those women living with the High Peak area. This community service is commissioned by Derbyshire CCG and is based at Buxton Hospital. It includes a satellite consultant led antenatal clinic and an ultrasound service.

We inspected the maternity service as part of an unannounced inspection between 28 and 30 January 2020. We visited all clinical maternity areas within the hospital maternity department including the theatre suite. As part of the inspection we reviewed information provided by the trust about staffing, training and monitoring of performance.

During the inspection we spoke to over 50 members of the maternity team including midwifery assistants, associate practitioners, student midwives, midwives, midwifery managers, midwifery matrons, the head of midwifery, obstetricians of varying grades, anaesthetists and operating department practitioners and volunteer peer breastfeeding supporters. We spoke with six women using the service.

During the inspection we reviewed 15 sets of maternity records and eight prescription records.

## Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- The service did not have enough midwifery staff to care for women and babies. Staffing levels were not in line with national recommendations for safe maternity care provision.
- Women could not always access the service when they needed it. At other times, services such as the birth centre were not available due to staff being redeployed. The number of times that the service had closed to admissions had progressively increased.
- The midwife to birth ratio had fallen and the provision of 1:1 care of women in labour had decreased.
- Maternity staff compliance with mandatory training in key skills was below local and national targets.
- Compliance with safeguarding children level three was below local and national recommendations.
- Although we observed the World Health Organisation Five Steps to Safer Surgery carried out correctly during a caesarean section birth that we observed, the service had not completed any audits to ensure these were completed at other times in both maternity theatres and birthing rooms.

# Maternity

- Managers did not monitor the effectiveness of the service with local audits to make sure staff were competent.
- Only 75% of midwives in the department had had an appraisal in the 12 months immediately preceding the inspection against the trust target of 95%.
- Following our last inspection, we gave the service actions that it should take to improve. These had not all been addressed.

However:

- The service-controlled infection risk well.
- Staff gave women enough to eat and drink and gave them pain relief when they needed it.
- Staff worked well together for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated women with compassion and kindness, respected their privacy and dignity, took account of their individual needs and helped them understand their conditions. They provided emotional support to women, families and carers.
- The service planned care to meet the needs of local people, took account of women's individual needs, and made it easy for people to give feedback.

## Is the service safe?

**Requires improvement** ● → ←

Our rating of safe stayed the same. We rated it as requires improvement because:

- Maternity staff compliance with mandatory training in key skills was below local and national targets.
- Although staff that we spoke with understood how to protect women from abuse and the service worked well with other agencies to do so, training compliance for level three safeguarding for midwives and medical staff, was below or well-below local and national recommendations.
- Following the last inspection, we told the trust they should consider installing neonatal resuscitaires in all the birthing rooms, but they had not.
- Although we observed the World Health Organisation Five Steps to Safer Surgery carried out correctly during a caesarean section birth that we observed, the service had not completed any audits to ensure these were completed at other times in both maternity theatres and birthing rooms. Therefore, we were not assured that there was any leadership oversight of such safety monitoring within the service.
- The service did not have enough midwifery staff to care for women and babies. The service had identified shortfalls, and, at the time of our inspection, labour ward co-ordinators were not supernumerary. This was not in line with national recommendations for safe maternity care provision.
- Community midwives transported medications for home birth in a variety of ways. For example, they transported two or three different vials of medication in a plastic takeaway box meant for one specific medication transported them loosely. As different types of medication were in the same box, this did not provide assurance that the risk of administration of the wrong medication being given in an emergency had been fully addressed. We were also concerned that medication vials were not protected during transit, meaning they could be damaged and unsuitable for use when needed.

# Maternity

However:

- The service-controlled infection risk well. Staff used equipment and control measures to protect women and babies, themselves and others from infection. They kept equipment and the premises visibly clean.
- Staff completed and updated risk assessments for each woman and took action and removed or minimised risks. Staff identified and quickly acted upon women at risk of deterioration.
- The service had enough medical staff and allied health professionals with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service mostly managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

## Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.
- Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural and other needs.
- Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Midwives, obstetricians and other healthcare professionals worked together as a team to benefit women and babies. They supported each other to provide good care.
- Key services were available seven days a week to support timely care.
- Staff gave women practical support and advice to lead healthier lives.
- Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit women's liberty.
- Staff always had access to up-to-date, accurate and comprehensive information on women's care and treatment. All staff had access to an electronic records system that they could all update.

However:

- The service did not provide any evidence that they regularly monitored the effectiveness of care and treatment through local audits.



# Maternity

- None of the staffing groups in maternity had met the trusts target of 95% for appraisal completion.

## Is the service caring?

**Good** ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs.
- Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

## Is the service responsive?

**Requires improvement** ● ↓

Our rating of responsive went down. We rated it as requires improvement because:

- People could not access the service at all when they needed to at certain times. Between January 2019 and December 2019 inclusive the service closed the unit to admissions on 25 separate occasions for a total of 165 hours and 42 minutes in total. During these periods 49 woman who had booked for maternity care at this service were diverted to a neighbouring maternity unit for care. Furthermore, such closures have increased for the last three years from four in 2017, 14 in 2018 and 25 in 2019.
- We were told that the birth centre closed to admissions at times of staff shortages and high acuity. However, the service did not monitor these instances at all times so were unable to tell us how often women had been unable to access this birthing option.

However:

- The service mostly planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

## Is the service well-led?

**Requires improvement** ● ↓

Our rating of well-led went down. We rated it as requires improvement because:

# Maternity

- The service did not have a documented vision and strategy for what it wanted to achieve.
- Leaders and teams did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues put into actions to reduce their impact.
- Issues highlighted at the last inspection had not all been resolved, and the unit closures were becoming increasingly more frequent.
- The service had not completed any audits to ensure the World Health Organisation Five Steps to Safer Surgery were completed in both maternity theatres and birthing rooms. Between April 2019 and December 2019, the service had only completed audits for one of the 18 scheduled occasions. Therefore, we were not assured that there was any leadership oversight of such safety monitoring within the service.
- Managers did not monitor the effectiveness of the service with local audits to make sure staff were competent. Following the inspection, we requested local audits that had been carried out to monitor the safety of women and babies but were not provided with any.
- Only 75% of midwives in the department had had an appraisal in the 12 months immediately preceding the inspection against the trust target of 95%.

However:

- Leaders supported staff to develop their skills and take on more senior roles.
- Staff felt respected, supported and valued. They were focused on the needs of women receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women, their families and staff could raise concerns without fear.
- Leaders and staff actively and openly engaged with women, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women.
- Staff were committed to continually learning and improving services. Understanding of quality improvement methods and the skills to use them was being developed.

# Services for children and young people

Requires improvement  

## Key facts and figures

Stockport NHS Foundation Trust has an integrated children's service. The children's Treehouse unit at Stepping Hill Hospital has 32 inpatient beds, a two bed HDU, a four bed surgical day case area and a paediatric assessment unit which is open from 9am till 10pm.

The service provides elective and non-elective care for children with medical and surgical conditions. Paediatric surgical specialities include emergency surgery and orthopaedic procedures, day case elective lists for ENT, dental, general surgery, ophthalmology and orthopaedics. Day case dental extraction theatre services are provided by the dental teams in the day case suite, supported by a paediatric nurse.

The service has eight assessment beds with direct access from GPs and takes children directly from the emergency department for medical assessment and observation. The children's unit provides open access for children with complex and chronic conditions, as well as children discharged under the care of community teams.

The service provides shared care with tertiary children's services for a number of conditions. For example, children with cystic fibrosis share care between Stockport NHS FT and another nearby NHS Foundation Trust.

The integrated service has close links between inpatient areas and the children's community nursing team (CCNT), facilitating early discharge and providing seamless care for children with chronic and complex conditions. Paediatric consultants work across both the acute and community settings to provide continuity of care for children and their families.

The trust had 6,153 spells from July 2018 to June 2019.

Emergency spells accounted for 88% (5400 spells), 9% (580 spells) were day case spells, and the remaining 3% (173 spells) were elective.

We inspected the children's service as part of an unannounced inspection (they did not know we were coming) between 28 and 30 January 2020. We visited inpatient wards on the children's and neonatal unit, children's outpatient department and theatres. As part of the inspection we reviewed information provided by the service about staffing, training and monitoring of compliance.

During the inspection we spoke with 38 members of staff of all grades including senior leaders of the service, doctors, nurses, play specialists, therapists, and administrative staff. We also spoke with representatives from other organisations. We spoke with 4 parents and carers of children and young people who were using the service at the time of our inspection. We reviewed a sample of 17 patient records, including prescription charts and care plans.

## Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- Staff did not always assess risks to patients and act on them. They did not always record environmental risk assessments for children and young people with mental health needs.
- The service did not always have enough staff to care for patients and keep them safe. Staff had not always completed training in key skills.

# Services for children and young people

- Although staff understood how to protect patients from abuse, there was low compliance for completion of the required level of children's safeguarding training.
- The service reported safety incidents but opportunities for shared learning were limited.
- Managers did not always make sure staff were competent. Whilst staff said they felt supported, there was a mixed culture with many staff sharing anxieties about feeling ill equipped to meet the demands in the service.
- Staff did not always complete accurate records of fluid intake for children.
- Key services were not always available seven days a week.
- Leaders did not always manage the priorities in the service. The service did not have a vision for what it wanted to achieve. The service had a system to identify risks but actions to reduce and mitigate risks were not always progressed in a timely way.

However

- The service controlled infection risk well. and kept good care records. They managed medicines well.
- Staff provided good care and treatment, gave children and young people enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service. Staff worked well together for the benefit of children and young people, advised them and their families on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated children and young people with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to children and young people, families and carers.
- The service planned care to meet the needs of local people, took account of children and young people's individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Staff were focused on the needs of children and young people receiving care and were clear about their roles and accountabilities. The service engaged well with children, young people and the community to plan and manage services and all staff were committed to improving services continually.

## Is the service safe?

**Requires improvement** ● → ←

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service provided mandatory training in key skills to all staff but did not always make sure everyone completed it. Completion of mandatory training for nursing and medical staff did not meet trust targets.
- Clinical staff had not completed specific training on recognising and responding to children and young people with mental health needs, learning disabilities and autism.
- Staff had not always completed the required level of safeguarding training and oversight of this was unclear.
- The service did not always have enough staff to care for patients and keep them safe.
- Staff did not always complete risk assessments where required. They did not always record environmental risk assessments for children and young people with mental health needs.

# Services for children and young people

- Although staff reported incidents, systems for sharing learning were limited. Not all staff were aware of recent incidents and medicines errors occurring in the service.
- Staff did not always maintain up to date care plans and fluid balance charts.

However

- The service controlled infection risk well and premises appeared clean.
- Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.
- Staff kept clear and up to date records of children and young peoples' care and treatment and stored these securely.

## Is the service effective?

**Requires improvement** ● ↓

Our rating of effective went down. We rated it as requires improvement because:

- The service did not always make sure staff were competent for their roles. Completion of appraisals was below trust targets.
- Staff did not always know how to support children, young people and their families who were experiencing mental ill health. Nurses frequently needed to care for children and young people admitted to the ward whilst they were awaiting assessment by specialist mental health practitioners.
- There had been changes in provision of staff training and competencies for children's high dependency care. Supervision for less experienced staff was not always available due to ward pressures.
- Staff did not always complete induction programmes or supernumerary practice due to daily workload demands.
- In both the children's and neonatal service there had been numbers of staff retiring or leaving the service, resulting challenges in skill mix.
- Key services were not always available seven days a week to support timely care for children, young people and their families. Therapy services were not routinely available at weekends.
- Staff did not always complete fluid balance charts accurately for children.

However;

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for children, young people and their families' religious, cultural and other needs.
- Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.

# Services for children and young people

- Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.
- Staff gave children, young people and their families practical support and advice to lead healthier lives and supported children, young people and their families to make informed decisions about their care and treatment.
- Staff always had access to up-to-date, accurate and comprehensive information on children and young people's care and treatment. All staff had access to an electronic records system that they could all update.

## Is the service caring?

Good  

Our rating of caring went down. We rated it as good because:

- Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to children, young people, families and carers to minimise their distress. They understood children and young people's personal, cultural and religious needs.
- Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

## Is the service responsive?

Good   

Our rating of responsive stayed the same. We rated it as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.
- Staff used transition plans to support young people moving on to adult services. Staff supported children and young people living with complex health care needs, by using 'This is me' documents and patient passports.
- Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

However;

- Children and young people with mental health needs admitted to the children's ward did not always have their needs provided for appropriately
- There had been ward closures during times of high demand, although people could mostly access the service when they needed it and received the right care promptly.

# Services for children and young people

## Is the service well-led?

**Requires improvement** ● ↓

Our rating of well-led went down. We rated it as requires improvement because:

- Although leaders had the skills and abilities to run the service and understood the issues the service faced, they did not always manage the priorities.
- The service did not have a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were dependent on progress in regional developments within the wider health economy.
- The culture in the service was mixed. Although staff told us they felt their managers were supportive and said they felt respected, many shared an underlying anxiety about the pressures of working in the service.
- Governance systems and processes were identified, however there was a lack of robust oversight of key performance areas in the service.
- Although leaders and teams had a system to identify risks, key risks were not always identified and actions to reduce the impact of risks were not always progressed.
- Although staff were committed to learning and improving services, they had limited understanding of quality improvement methods and this was not embedded in practice.
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However;

- Leaders were visible and approachable in the service for children, young people, their families and staff. They supported staff to develop their skills and take on more senior roles.
- Staff were focused on the needs of children and young people receiving care. Children and young people, their families and staff could raise concerns without fear.
- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- The service collected data. Staff could find the data they needed, in easily accessible formats, to understand performance and make decisions.
- Leaders and staff actively and openly engaged with children, young people, their families, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for children and young people. Leaders encouraged participation in research.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

**Please note:** Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website [www.cqc.org.uk](http://www.cqc.org.uk))

**This guidance** (see [goo.gl/Y1dLhz](http://goo.gl/Y1dLhz)) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

#### Regulated activity

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

#### Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

#### Regulated activity

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

#### Regulated activity

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

#### Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

#### Regulated activity

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

#### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing



This section is primarily information for the provider

## Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

### Regulated activity

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

### Regulation

Section 29A HSCA Warning notice: quality of health care

# Our inspection team

Judith Connor, Head of Hospital Inspection, led this inspection. An executive reviewer, Peter Lewis, Chief Executive, supported our inspection of well-led for the trust overall.

The team included a further five inspectors, an assistant inspector, two inspection managers and nine specialist advisers.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.